Mental Health, Chemical Abuse and Dependency Services Division

RECOVERY PLAN FOR MENTAL HEALTH SERVICES

August 2005

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King County Mental Health, Chemical Abuse and Dependency Services Division

Recovery Plan for Mental Health Services

Introduction

For the past several years, the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) has worked towards creating a service system that promotes the principles and practices of recovery for consumers who receive services through the King County Mental Health Plan (KCMHP). Although MHCADSD is responsible for both mental health and chemical dependency services, and recovery oriented practices apply to both arenas, the challenges that each service delivery system faces are very different and will need separate and distinct planning processes. The chemical dependency system already embraces the concept of recovery. Therefore, the current plan focuses on recovery oriented mental health services.

"Recovery" is the belief that individuals whose lives have been seriously disrupted by a mental illness can not only achieve management of their symptoms, but can also regain what has been lost. For the purpose of this document, "consumer" refers to individuals or, in the case of children and youth, their families or guardians.

Recovery principles include:

1. Services that are consumer centered and driven
2. Assessment and treatment planning that is strengths based
3. Reduction or remission of symptoms
4. Development or the restoration of normative life roles
5. Active development and involvement of natural supports
6. Full community participation

Emerging best practices in both the mental health and chemical dependency treatment fields stress the importance of adopting the above principles in order to effectively assist consumers in achieving an improved quality of life. Implementation of these practices demonstrate that, by enabling the achievement of life roles through interdependent relationships with others, consumer involvement in criminal justice, chemical dependency and hospitalization services decreases.

MHCADSD's strategies to date to promote recovery have included:

1. Sponsoring training and workshops on recovery;
2. Collaborating with the Metropolitan King County Council to develop a Recovery Ordinance in order to provide "legal backbone" for recovery-based system changes and outcomes assessment;

3. Developing policies and procedures to include consumer voice, cultural competency, cross-systems collaboration, community based services, natural supports and individualized and tailored care into services;
4. Beginning to assess the degree to which the KCMHP provider network has incorporated recovery practices into day-to-day services; and
5. Developing a residential initiative that transforms our current residential program from a facility based model to a supportive housing model.

These strategies have resulted in some basic components of an infrastructure that supports recovery. The strategies, however, have been implemented as individual activities by MHCADSD and not from the framework of an organized plan. In order to ensure that the system continues to develop consistently, a comprehensive and strategic plan is needed.

What is known about Recovery? – A Literature Review

Over the years, the vision of recovery has been refined by consumers, self help groups, and advances in treatment that provide a holistic approach to services. More recently, recovery has received renewed recognition by key stakeholders at both the national and local level. The recent publication of "The President's New Freedom Commission on Mental Health" brought recovery to the forefront of best practices in mental health. The Commission's findings emphasized that recovery was a viable direction for public mental health agencies. As the President's New Freedom Commission on Mental Health Report states, "The goal of a transformed mental health system is recovery -- the transformed mental health system promotes learning, self monitoring and accountability." Currently, most of the literature about recovery is based on services to adults. Therefore, we will need to customize our approaches when applying the research to children and older adults.

Recovery is a process, not an outcome, and it is individually determined. Anthony states that "Recovery is a deeply personal unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with illness-caused limitations." (Anthony, 1991, p.13-14).

Although recovery is an individual process, there are identifiable stages of recovery that include dependence, independence and interdependence, as well as unawareness, awareness and acceptance. The Ohio Department of Mental Health has developed a comprehensive overview of clinical care as it pertains to the role of consumer, clinician, and community support at various levels of engagement from dependent and unaware to independent and aware, in the recovery process (Hogan, 1999).

Deegan states that clinicians need to be flexible in meeting consumers' individual needs and levels of readiness for recovery. "It is important to understand that for most of us recovery is not a sudden conversion experience." Clinicians and the service delivery system must be willing to offer a variety of services and be willing to implement services at those turning points so they fit the consumer's level of interest and willingness when the consumer is ready to make movement (Deegan, 1998 p. 11-19).

As Deegan notes, central to recovery is the role of the clinician in offering hope-inspiring strategies and services. "Hope is the turning point that must quickly be followed by the willingness to act." Among other recovery based systems, the Ohio Department of Mental Health has identified the clinician's emphasis on hope and the ability to develop trusting relationships as key principles. (Hogan, 1999, Guiding Principle VI).

It is important for the system and clinicians to recognize that inspiring hope can be an extended and non-linear process. Consumers may not accept the offer of hope at certain times in their process but may be ready at a later point. Clinicians need to persist in order to be ready for that key time in which the consumer becomes aware, accepting, and interested in pursuing his/her own recovery (Hogan, 1999).

Although clinicians can play an integral role, it is ultimately up to the consumer to move forward in the recovery process. Deegan comments:

> We can make the finest and most advanced rehabilitation services available to the psychiatrically disabled and still fail to help them. Something more than just "good services" is needed, e.g. the person must get out of bed, shake off the mind–numbing exhaustion of the medication effects, get dressed, overcome the fear of the crowded and unfriendly bus, to arrive at the program and face the fear of failure. In essence, disabled persons must be active and courageous participants in their own rehabilitation project or that project will fail (Deegan, 1998, pp 11-19).

A recovery-oriented system promotes consumers' self-reliance, rather than reliance on the clinician. The development of self-reliance is an active process in which clinicians promote consumers' personal responsibility for their own recovery, often in collaboration with friends, family, supporters, and other professionals. The challenge to both the consumer and the clinician is to find ways to increase the support, skills, and means of self-managing the effects of the mental illness. As consumers begin to direct their recovery, the mental health professional maintains the role of the clinician, and additionally serves as a facilitator to the consumer. This includes facilitating opportunities for the consumer to:

1. Strengthen his or her support system;
2. Learn and gain support from others who have experienced recovery (peer support); and
3. Increase self and family knowledge about mental illness and treatment options in order to make educated choices (Hogan, 1998; Ridgeway, 1999).

A recovery-oriented mental health system requires a change in the perspectives that direct programming and service delivery. Anthony states that:

> In the past, mental health systems were based on the belief that people with severe mental illness did not recover, and that the course of their illness was essentially a deteriorative course or, at best, maintenance course. A recovery vision of service is grounded in the idea that people can recover from mental illness, and the service delivery system must be constructed based on this knowledge (Anthony, 1991, p. 13-14).

Fisher (1995) suggests that services should be based on an enhanced self-management model.

> Self-managed care is consumer-directed, multi level, and strength-based planning to genuinely assist a person in gaining a meaningful role in society. This planning is contrasted to maintenance-based treatment planning which by its nature is professionally directed to correct pathology (Fisher, 1995-96, p. 37).

The elements that recovery-oriented services should embody, which are applicable across cultures and age groups include:

1. Hope and faith;
2. Self management and autonomy;
3. Tolerance and forgiveness;
4. Restoration and personal growth;
5. Peer support and community life;
6. Acceptance and self awareness;
7. Adaptability and capacity to change; and
8. Dignity and self respect (American Association of Community Psychiatrists' Guidelines for Recovery Oriented Services).

Ridgeway (1999) states that implementing the common elements of recovery-based services, first requires creating a new attitude among consumers and service providers. Ridgeway states that in order to embrace the concepts listed above, the system needs to work toward:

1. Creating a shared vision of recovery through education and training of all parties involved.
2. Building local leadership and work groups that focus on recovery.
3. Supporting consumer operated services.
4. Involving consumers in all levels of the system.
5. Identifying best practices and customizing them to meet local needs.
6. Developing programming that focuses on relapse prevention and symptom management.
7. Building consumers' self-sufficiency and decision-making skills.
8. Using contracts and financing mechanisms to support recovery oriented programming and resources (e.g. requiring and/or funding peer to peer support, employment supports and opportunities, outcomes that focus on quality of life, recovery, and self fulfilling functioning).
9. Promoting activities outside the mental health facility; and
10. Sponsoring stigma reduction initiatives.

What is a Recovery Oriented System?

A recovery oriented mental health system is different from a community support treatment system, which is the community mental health treatment paradigm that has been in place since the 1970s, and which typifies services currently provided within the KCMHP. The table below displays the differences between a community support paradigm and a recovery oriented paradigm.

Community Support Paradigm	Recovery Paradigm
Focuses on symptoms, problem behaviors, pathologies	Focuses on the whole person, including the person's assets, capabilities, latent abilities, and aspirations
Consumers' activities are associated with treatment, the mental health agency, or the treatment staff	Consumers pursue activities in the larger community with a goal of full integration into that community
Treatment planning is led by staff and is program and facility based	The consumer and clinician negotiate the treatment plan to which both contribute their unique knowledge and skills. Treatment is individualized and community based.
The goal is to achieve and maintain stability	The probability of improvement in functioning is emphasized.
The provision of psychotropic medication for stability, psychotherapeutic approaches to treatment; and case management – the consumer is often a passive recipient of these services	Medications are used to treat symptoms, the reoccurrence of symptoms and manage any side effects that might impede recovery. Treatment is focused on training and teaching; case management is offered to assist the consumer and consumers' natural supports.
The approach to service provision tends to be paternalistic and seeks to protect consumers from risk and stress	Foster risk taking as a means for consumers to learn, grow and change
The consumer is dependent on others to meet basic needs and control symptoms	Consumers develop personal understanding and control of their symptoms
Consumers are expected to need ongoing services.	For some clients graduation from treatment is possible, and for all clients there is the expectation that some degree of recovery is possible

MHCADSD's vision of recovery is adapted from the President's New Freedom Commission on Mental Health:

> ***Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.***

MHCADSD has incorporated the three priorities of the Department of Community & Human Services within its vision of recovery: employment, housing, and diversion from the criminal justice system. The reasons for this include:

1. Many adult consumers report that their re-entry into the work force provided an impetus toward recovery in other life areas as well.
2. Living in decent, affordable housing, rather than being homeless or marooned in institutional settings, promotes recovery; and
3. Avoiding incarceration and reducing or eliminating criminal justice system involvement is essential in order to move forward in recovery and rebuild a hopeful, contributing life in the community.

MHCADSD describes a recovery-oriented system as one in which:

1. Consumers are actively involved in taking personal responsibility and ownership of their own recovery.
2. Clinicians bring meaningful knowledge and expertise to the recovery process.
3. Interventions are oriented toward consumer progress rather than stability.
4. The consumer believes that he or she can recover and this belief is supported by others who are important to the consumer. The individual service plan (or recovery plan) and progress notes either reflect the consumer's belief or include strategies and actions to foster it.
5. A primary focus for engagement and intervention is assisting consumers who have become dependent on the mental health system, and who may not seem interested in or capable of recovery, understand and be willing to try to move toward recovery.
6. Recovery is recognized as an ongoing process that is not linear -- setbacks may occur and can be overcome.
7. It is important to recognize all consumers have strengths and assets, and these are used in developing the recovery-oriented individualized service plan.
8. Services are customized, flexible, community-based, and respectful of age and culture.
9. Outcomes such as employment and education are important but are a consequence of a recovery oriented service plan rather than a specific definition of recovery; and
10. Medications are utilized as an important foundation to recovery oriented interventions.

Why Now?

There are three primary reasons for MHCADSD's increased emphasis on recovery.

1. <u>Best Practice</u>

   As the literature clearly states, recovery is integral to best practice because it moves consumers toward greater integration and involvement in life outside the mental health system. While MHCADSD has developed a mental health system that has kept many individuals stable and in the community, there is more work to be done in providing services that focus on assisting consumers to move beyond stability toward fuller community integration and recovery.

   (See below "Current KCMHP Infrastructure," p. 11)

2. Current Federal and State focus on recovery.

The need to transform the current mental health system has been discussed at all levels of government. In May of 2003 the President's New Freedom Commission on Mental Health published its findings. The findings identified strategies that would assist in maximizing the utility of existing resources, improve coordination of treatments and services, and promote successful community integration for individuals who have a serious mental illness. In July 2005 the state legislature passed the Engrossed Second Substitute House Bill (E2SHB) 1290 which modified the Community Mental Health Services Act, ensuring that the delivery of mental health services focus on the concepts of recovery, resilience and evidence-based practices. Neither of these documents outlines a specific plan to transform the mental health system, but both clearly support the need for system transformation with a recovery emphasis.

3. KCMHP Recovery Status.

MHCADSD has reviewed several potential indicators of recovery in order to assess the state of the KCMHP in general. These indicators include findings from the recovery assessments and clinical chart reviews done in conjunction with the 2003 and 2004 provider contract compliance site visits, a survey assessing the need for continued residential treatment for consumers residing in KCMHP supervised living facilities, measures from the KCMHP report card, the state Mental Health Division's (MHD's) annual measure of consumers' involvement in their treatment[1], and preliminary data from the MHD's Telesage outcome project. The findings from each of these areas are below.

Contract compliance site visit findings. Every year MHCADSD visits each KCMHP provider to assess contract compliance. The content of the site visits varies and depends on the results from the previous year's site visit and current areas of interest to MHCADSD. In 2003, the site visit clinical emphasis was on basic compliance with KCMHP policy and procedures in the areas of intake and assessment, treatment planning, crisis plans, and clinical documentation of progress. Findings of significance that related to recovery principles were noted in each of these areas, specifically:

a. In both the intake/assessment and treatment plans, vocational and/or educational goals were insufficiently addressed
b. Consumer strengths were insufficiently addressed in the intake/assessment and were not sufficiently integrated into the treatment plan
c. Crisis plans did not show adequate evidence that consumers participated in their development and did not include explicit descriptions of baseline behavior or effective interventions
d. Progress notes were not specific as to consumers' clinical status and response to the treatment plan

Site visit findings also indicated that there was limited use of advance directives. Advance directives are considered critical in a recovery oriented system because they allow consumers to stipulate the supports to be involved and interventions to be implemented should relapse occur.

In part because of the findings from the 2003 site visit, the 2004 contract compliance site visits focused on crisis services. The findings essentially showed no improvement from the 2003

[1] This measure is designated as a statewide clinical quality improvement project, as required by the federal Balanced Budget Act (42CFR Subchapter C—Medical Assistance Programs, Part 438—Managed Care, Subpart D—Quality Assessment and Performance Improvement).

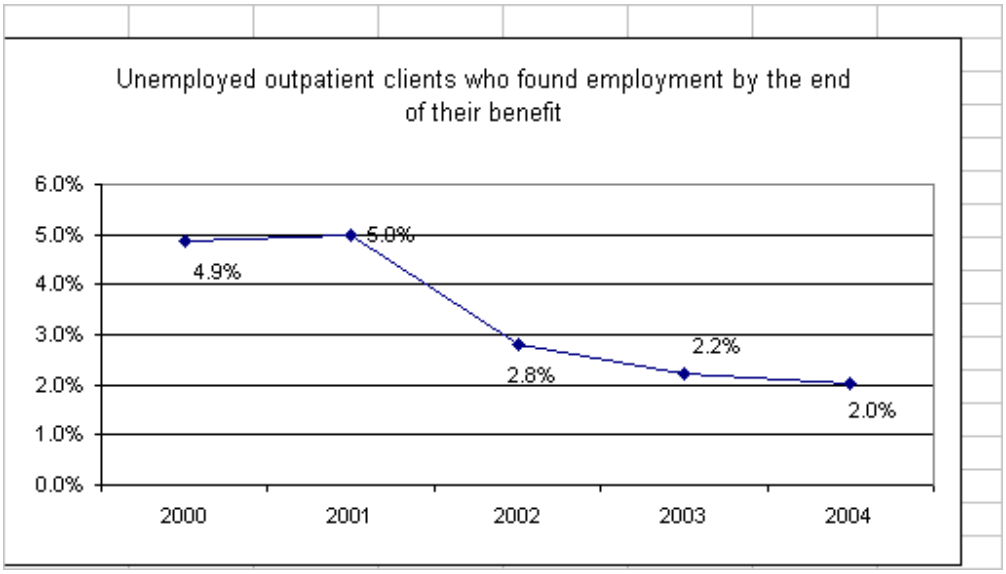
findings but did add a Recovery Baseline Assessment (Appendix A). The intent for the recovery assessment was to gather baseline information about services provided to consumers in order for MHCADSD to develop recovery oriented technical assistance strategies.

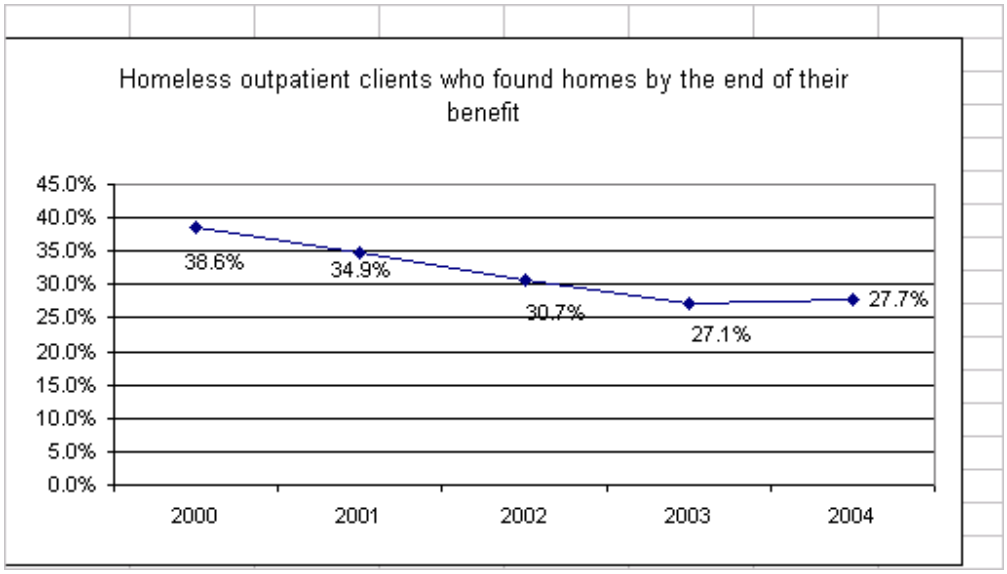
The recovery assessment included the following elements of treatment records intake/assessment, the treatment plan, and clinical documentation. There were two scores for each area: "reflects recovery well" and "reflects recovery less well." The findings demonstrated marked variability across the provider network.

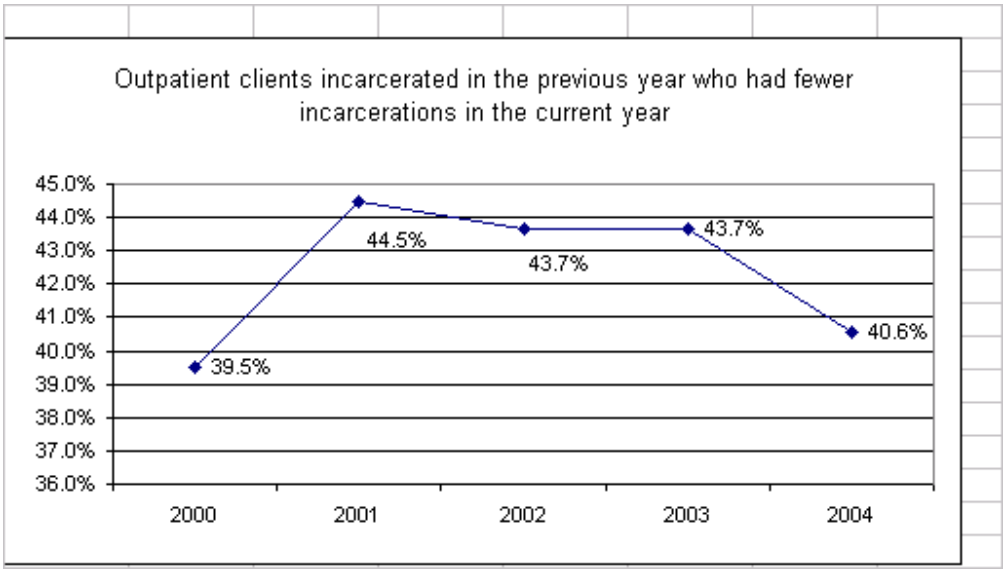
Eighteen percent of the items reviewed “reflected recovery well,” and 82% of the items reviewed “reflected recovery less well.” Overall, fewer than 50% of the total records reviewed reflected recovery well. Although there were outstanding examples of recovery oriented services, the majority of the clinical records reviewed did not document recovery-oriented processes. The areas that reflected recovery the least well were primarily in the intake/assessment, including the consumer's beliefs about recovery, identifying the consumer's personal mechanisms for coping, and assessing the degree to which the consumer's beliefs about recovery are supported by others. Treatment plans and assessments scored similarly in the area of identifying strategies to increase consumers’ coping abilities and ability to gain further independence.

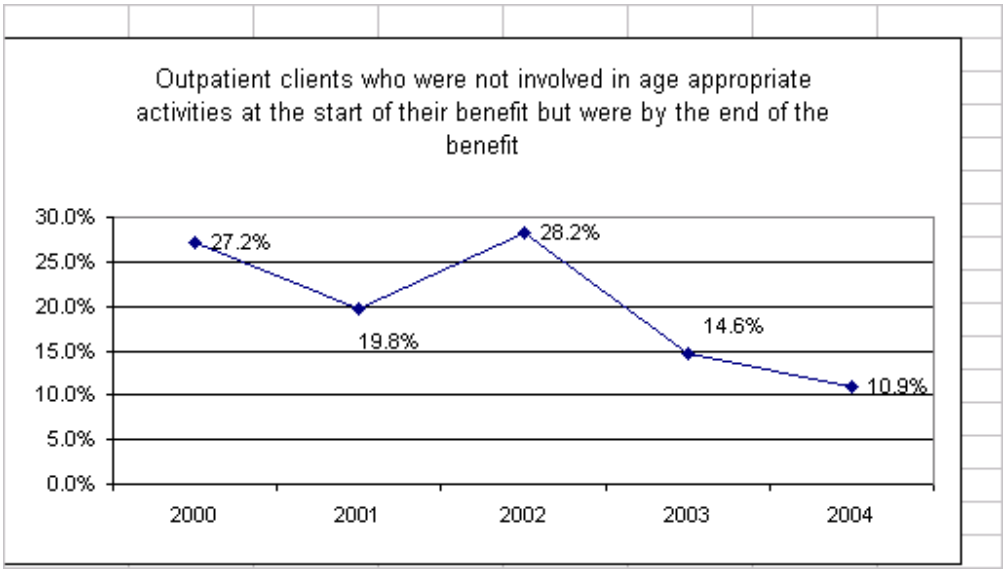
Need for Supervised Living. In 2002, United Behavioral Health (UBH), MHCADSD's administrative services organization for mental health managed care at that time, did a survey of consumers who were residing in KCMHP supervised living facilities. UBH found that about 32 per cent of the consumers reviewed did not appear to meet the medical necessity criteria for supervised living. MHCADSD repeated this study in 2003, with similar results. Two of the related findings were that (1) there were insufficient community-based resources and programs to successfully enable consumers to move from facility-based to community-based housing, and (2) residential and case management staff did not believe that many of the consumers could successfully move to more independent housing.

Measures from the KCMHP report card. The KCMHP Report Card includes, among other data, outcomes for consumers who are enrolled in outpatient services. Many of the outcomes are of interest to a recovery-based system, including consumer employment, homelessness, involvement with the criminal justice system, and involvement in activities that are normal for the person's age and culture. The following charts show performance changes in these areas between 2000 and 2004. See Appendix B for additional data.


Unemployed outpatient clients who found employment by the end of their benefit
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
4.9%
5.0%
2.8%
2.2%
2.0%
2000
2001
2002
2003
2004


Homeless outpatient clients who found homes by the end of their benefit
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
38.6%
34.9%
30.7%
27.1%
27.7%
2000
2001
2002
2003
2004


Outpatient clients incarcerated in the previous year who had fewer incarcerations in the current year
45.0%
44.0%
43.0%
42.0%
41.0%
40.0%
39.0%
38.0%
37.0%
36.0%
39.5%
44.5%
43.7%
43.7%
40.6%
2000
2001
2002
2003
2004



It is clear that performance in all areas has declined. One very real contributor to this is the reduction in funding that the KCMHP has faced. Since 1999, per consumer revenues have decreased by 16 percent. Given that it is unlikely that funding will return to the 1999 levels, it is clear that we must find a new way of doing business in order to maximize the impact of the resources we have available.

State MHD Consumers' Participation in Treatment. Every year the state Mental Health Division (MHD) conducts a statewide survey of consumers' perception of publicly funded mental health services.[2] The sample size for each regional managed care plan (the KCMHP in King County) is large enough to permit comparisons among the regions as well as to create a statewide average score as a benchmark. The latest surveys for youth or parents/caregivers and adults showed that consumers served by the KCMHP rated their perception of participation in treatment slightly higher than the statewide average. Sixty nine percent of youth or parents/caregivers agreed or strongly agreed that they did participate in treatment, compared to the statewide average of 68 percent. Sixty seven percent of adults agreed or strongly agreed that they participated in their treatment, compared to the statewide average of 66 percent. Although higher than state averages, the KCMHP scores indicate room for improvement.

State MHD Telesage outcomes. The state MHD implemented a statewide clinical outcome reporting system—known colloquially as Telesage -- and by contract requires the regional plans, and therefore the mental health providers, to participate in it. There are slightly different versions for youth or parents/caregivers and for adults, but each questionnaire has questions that are either identified as recovery (adults), or support recovery (youth and parents/caregivers). Consumers complete the questionnaires at intake, at three months after beginning services, at six months, and every six months thereafter. The data through March 2005 show that KCMHP consumers have slightly higher scores than the statewide average. For youth, the average score in the "hopefulness" domain was 16.5 out of

[2] For more information about this survey, see the web site for the Washington Institute for Mental Illness Research and Training, Western Branch, www.wimirt.washington.edu. See also the Washington State Department of Social and Health Services, Mental Health Division, State-wide Publicly Funded Mental Health Performance Indicators report, available by calling 1-888-713-6010.

24 possible (higher is better) compared to a statewide average of 15.9; for parents/caregivers on the same domain the KCMHP respondents average score was 16.9 compared to a statewide average of 15.7. For adults, the average total recovery scale score was 23.5 out of 35 possible points (higher is better) compared to a statewide average of 22.8. Appendix C shows the specific indicators and scores.

The summary statement for all of the above indicators is that the KCMHP is not yet a recovery-oriented system, although some progress is being made.

Current KCMHP Infrastructure

MHCADSD has instituted policies and procedures, programs, and services to support recovery. Specific policy and procedures with recovery-oriented requirements are:

1. Comprehensive intakes and assessments that focus on accurate, strength based, and holistic assessment of consumer needs in all life domains.
2. Treatment plans that are individualized, tailored, and customized to meet the needs of the individual and family.
3. Ongoing coordination and collaboration with other systems with which a consumer may be involved.
4. The provision of a variety of service modalities—such as case management, medication management, individual and group therapy—to address different types of consumer needs.
5. The encouragement of community involvement by identifying appropriate community activities and natural supports.
6. The development of crisis plans to ensure that crises are managed and resolved in the least restrictive manner.
7. The development of advance directives to give consumers a voice regarding how services will be provided in times of relapse.
8. Assistance by the outpatient provider when it is appropriate for the consumer to seek hospitalization; and
9. The continued involvement of the outpatient provider when a consumer is hospitalized to help with discharge planning, identifying appropriate community resources, and assisting the consumer to return to the community as soon as possible.

The array of recovery-oriented programs and special services currently available include:

1. Crisis services available 24 hours per day seven days a week. The crisis services are age group specific (children, adults, and older adults).
2. Inpatient diversion options for all age groups to promote community-based care.
3. Liaisons who ensure appropriate access for consumers who are eligible for ongoing care and who are being discharged from psychiatric inpatient units and the state hospital.
4. A Client Services Coordinator to provide information and referral and to assist consumers to resolve their concerns.
5. A consumer run Ombuds service that assists consumers to resolve complaints.
6. An advisory board that has consumer and advocate representation.
7. A consumer staffed Quality Review Team that focuses on quality of care issues identified by consumers; and
8. A residential plan that promotes reduction of facility-based care and development of supported housing.

As the KCMHP continues to focus on developing a recovery-oriented system for all consumers, efforts need to spotlight many of the practices from the Children and Families in Common Grant (CFIC). This grant focused on consumer and family empowerment, creating natural supports, holistic assessment, and enhancing consumer inclusion in the community, all of which are at the core of any recovery-based system. The grant also focused on creating treatment plans in a partnership between the consumer and clinician. MHCADSD has followed up by releasing the 2005 Children's Mental Health Plan that is the plan for sustaining gains made under the grant and disseminating best practices throughout the child-serving system.

RECOMMENDATIONS

The fundamental challenge is how to create and implement a system that effectively promotes recovery. The change is not about creating new types of programs--it is about re-orienting policymakers, provider leadership, clinicians, consumers, and advocates to a new approach in mental health treatment. This approach includes providing services in a manner that increases consumers' participation in service planning, design, and implementation at all levels, and encourages consumers to see beyond the parameters of the mental health center. It is an approach that includes expectations for recovery as a real and achievable goal for many consumers.

A change of this magnitude touches all aspects of service provision. As a system, we will need to evaluate the implications, including reviewing the financial model, staffing needs, provider day-to-day operations, and evaluation of services.

Action Plan for Creating a Recovery Oriented Mental Health System in King County

MHCADSD will utilize a multi-year, phased process for system change. This approach is similar to what is being successfully pioneered statewide in Connecticut.[3] MHCADSD recognizes the vital importance of creating a strong shared vision among all stakeholder groups around the values, goals, and objectives for a recovery-oriented system. The Recovery Plan provides a blueprint for transition to a recovery-oriented system.

MHCADSD recognizes that this system transformation processes will involve changes that have direct costs (such as funding supported employment for working-age consumers) and changes that do not have direct costs (such as recovery oriented changes in treatment plan development). Negative changes in KCMHP funding may result in delays in the implementation of portions of this plan that involve direct costs. MHCADSD intends to continue to move forward, however, with at least those portions of the plan that do not have direct costs.

Phase I. Create a Shared Vision of Recovery (2005-2006)

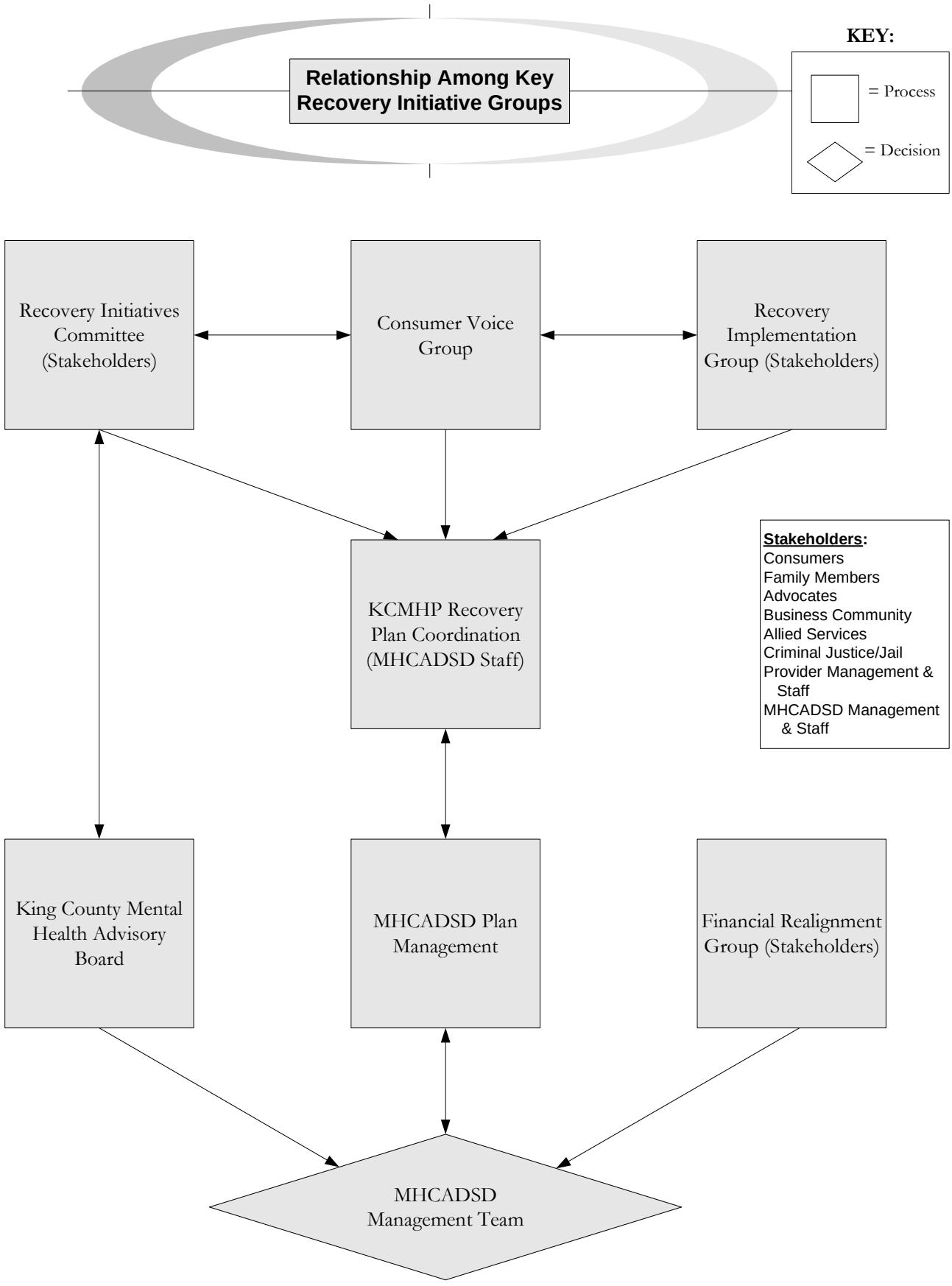
The primary tasks for this phase are:

1. Develop a shared vision of recovery.
2. Identify existing barriers to moving the system toward recovery.

[3] For more information on the process the state of Connecticut Department of Mental Health and Addiction Services has used to engender transformation to a recovery oriented mental health system, please go to their web site: http://www.dmhas.state.ct.us/recovery.htm

3. Develop a financial model that supports a recovery oriented system.
4. Develop venues that enhance consumers' participation.
5. Heighten awareness about recovery at multiple levels.
6. Continue to partner with NAMI and other community advocates in reducing stigma related to mental illness.
7. Convene workgroups (See description of workgroup tasks below); and
8. Begin work on establishing performance targets and system-wide measures.

To assure maximum stakeholder involvement in the implementation of these tasks, MHCADSD proposes to establish or sponsor a number of groups, each of which will have specific responsibilities. The flow chart that follows illustrates the composition of each group and their relationship with one another. Details about the groups can be found after the chart.


Relationship Among Key Recovery Initiative Groups
KEY:
= Process
= Decision
Recovery Initiatives Committee (Stakeholders)
Consumer Voice Group
Recovery Implementation Group (Stakeholders)
KCMHP Recovery Plan Coordination (MHCADSD Staff)
Stakeholders:
Consumers
Family Members
Advocates
Business Community
Allied Services
Criminal Justice/Jail
Provider Management & Staff
MHCADSD Management & Staff
King County Mental Health Advisory Board
MHCADSD Plan Management
Financial Realignment Group (Stakeholders)
MHCADSD Management Team

Recovery Implementation Group

Members of this group should be representative of all stakeholders, including consumers, advocates, agency staff, MHCADSD staff, allied systems, and other interested constituents. This group will have significant responsibility for implementation of the Recovery Plan and development of recovery initiatives. The specific activities include:

1. Developing concept definitions and system outcomes.
2. Identifying age appropriate recovery outcomes and performance measures; and
3. Establishing workforce training plans, including:
    a. Identifying training barriers.
    b. Recommending methods for implementing intensive recovery-based skill training for all contracted mental health providers during 2006-2008.
    c. Creating partnerships between MHCADSD and provider staff in the development of curricula and the provision of staff training.
    d. Identifying funding for training.
    e. Recommending policy and procedure and contract requirements that addresses competency expectations for provider staff; and
    f. Defining roles for consumers and advocates in providing training.
4. Exploring and identifying promising and best practices to replicate; and
5. Developing a plan to increase consumer involvement at all levels of the system, in conjunction with the Consumer Group.

Consumer group (to be named by group members)

The membership of this group will be limited to consumers of the KCMHP, with one MHCAHDS RPC staff liaison. Group members (not the County liaison) will be compensated for the time they spend attending meetings and other related activities. Members will:

1. Represent consumer voice in the design and implementation process.
2. Partner with the NAMI affiliates and other stakeholders in identifying consumers to participate with the group.
3. Comment on all KCMHP recovery initiatives.
4. Assure linkages to the Recovery Plan Coordination Group.
5. Develop strategies to increase consumer voice and influence in the system; and
6. Inventory existing consumer involvement in leadership throughout the KCMHP, for example, employment, board participation, and participation on quality improvement committees.

Recovery Initiatives Committee

This is a standing committee of the King County Mental Health Advisory Board (MHAB). Board by-laws mandate that this group is chaired by a member of the board, that at least two board members serve on the committee, and that the remaining members may include interested members of the community, including consumers, advocates, and agency staff. The Recovery Initiatives Committee is the conduit to the MHAB, and makes recommendations to the full board. This committee will:

1. Review and make recommendations related to the implementation of the Recovery Plan, including recommended policies.
2. Review and make recommendations on the revised King County Recovery Ordinance.

3. Review and comment on annual reports submitted to the King County Council as required by the Recovery Ordinance; and
4. Review annual summary reports describing King County providers' progress toward implementing recovery initiatives, and make recommendations to MHCADSD Management.

Financial Realignment Workgroup

This workgroup will include MHCADSD and provider staff and other stakeholders who have knowledge and experience in the design and development of reimbursement models. This work group will:

1. Examine current fiscal incentives/disincentives to implementing a recovery-based system.
2. Make proposals to realign incentives to support the implementation of recovery initiatives, including MHCADSD priorities of housing, employment, and criminal justice diversion.

MHCADSD Recovery Plan Coordination (RPC)

This is an ongoing, internal MHCADSD activity that will be chaired by a member of the MHCADSD management team. It will include key staff who work on various recovery initiatives (e.g. contracts, clinical, program development, fiscal).

The RPC will:

1. Coordinate all recovery activities, including program and resource development.
2. Communicate regularly with the other recovery committees to ensure that activities are complimentary and consistent with the Recovery Plan.
3. Ensure that KCMHP Policies and Procedures consistently reflect recovery.
4. Monitor progress on the implementation of recovery initiatives and committee/work group recommendations.
5. Develop a communication plan, with identified staff resources, to promote discussion and idea exchange with mental health agency clinical staff, supervisors and administrators, consumers, and advocacy groups.
6. Identify the best existing local KCMHP recovery practices and promote enhanced public recognition of individuals and programs exhibiting these best practices.

Additional Phase 1 tasks

In addition to the tasks that work groups will undertake in the first year, it will also be necessary to establish a dialogue with provider chief executive officers, clinical directors, and clients to:

1. Build a common understanding of the principles and goals of a recovery oriented system.
2. Discuss strategies for system transformation.
3. Identify initial standards, work tasks, and time frames.
4. Work toward a shared resolution of issues and concerns about the transformation process.
5. Identify opportunities for partnerships; and
6. Hold roundtable discussions to promote discussion with middle managers, direct service staff, consumers, and advocacy groups. Groups will elaborate on what a recovery oriented system is, how it differs from the current system, the types of problems it solves, which values that are different, what are workload implications, and related issues.

Phase 2: Initiate change (2006- 2008)

MHCADSD anticipates that existing or new work groups will be responsible for implementing the key tasks, as well as others yet to be identified, for the second year.

The tasks of this phase are to:

1. Realign fiscal resources:
   a. Identify funding to support provider-based recovery training initiatives for clinical staff and middle managers that are specific to each provider's recovery self-audit. Include training for managers on staffing models and the impacts on day-to-day operations.
   b. Consider targeting the Consumer Training Fund on increasing consumer participation in leadership trainings, with the purpose of training other consumers across the county.
   c. Continue to fund consumer pilot projects and ensure that selected projects are consumer-identified and run operations. Look for ways to support the development of consumer operated services that support recovery.
   d. Continue to explore grant and other funding opportunities that allow for further implementation of the recovery model.
   e. Continue to promote recovery-oriented housing by shifting funding to develop supported housing options for clients currently living in supervised living facilities.
   f. Recognize and identify agencies that exemplify recovery in action so that they can serve as training sites for administrative and direct practices.

2. Continue to increase awareness and engage in recovery-oriented quality improvement:
   a. Design or select a provider self-audit tool that assesses progress in implementing recovery practices and is submitted to MHCADSD annually.
   b. Set employment goals for the system and individual agencies for the 2007 contract year. Identify similar goals for housing, criminal justice diversion, and other core recovery dimensions.
   c. Design the content of a person-centered recovery plan. The format of the plan could be adapted according to provider needs.
   d. Review contracts and requests for proposals for the potential of incorporating peer support in program design.
   e. Reflect recovery-oriented clinical and administrative practices in contract language.

3. Engage in intensive MHCADSD and provider staff development:
   a. Promote understanding of evidence-based practices as defined by SAMHSA. Identify local evidence-based and best practices, and promote them. Consider how these models might be implemented and/or replicated in King County. Identify the needed resources and system modifications

4. Increase consumer voice and empowerment:
   a. Support, enhance, and expand on the current array of persons who can speak about their personal experience of recovery, such as participants in the NAMI “In Our Own Voices” program. Arrange for presentations in agencies, at consumer groups, and at family support groups. Develop positive media coverage about people in recovery in order to educate the public.

b. Implement Quality Review Team (QRT) sponsored forums that address the issue of consumers' empowerment and participation in their own treatment. Identify and recruit consumer and advocate organizations to participate in this process.
c. Work closely with consumers, advocacy groups, and providers to encourage the development and expansion of support groups.
d. Increase consumer involvement in reviews of requests for proposal and in the contract compliance processes.

Phase 3. Increase depth and complexity (2008-2010)

a. Participate with providers and other organizations in promoting stigma reduction initiatives through social marketing (i.e. public service announcements and newspaper articles).
b. Provide advanced training on recovery-oriented services and systems.
c. Continue providing technical assistance and knowledge transfer between agencies about recovery practices.
d. Continue evolution of performance measures and practice guidelines.
e. Continue implementation of policy/resource changes.

CONCLUSION

Developing a recovery-oriented system requires a paradigm shift. Consumers must become actively involved in their treatment and clinicians must become facilitators who assist consumers to achieve their goals. In order for consumers to develop or return to normative life roles, there must be an emphasis on creating and utilizing natural supports, developing normative activities outside of the mental health system, and living in community-based housing. The development of community connections and the involvement of natural supports will help to facilitate consumers' return to normative life roles as integrated members of the community.

MHCADSD is aware that making this paradigm shift will take time. We are committed to encouraging a learning environment so that all system participants, including MHCADSD staff, providers, and consumers, learn how to implement the recovery model within system constraints. We will continue to assess our system, gather information, create reasonable benchmarks and work with providers and consumers to implement this model together. Through the workgroups, MHCADSD will establish goals and measurements in collaboration with providers, consumers, and other stakeholders. Updates on progress will be reported regularly to the Metropolitan King County Council.

The ultimate goal of the transformation of the system is that consumers may achieve the promise of what the rest of the population takes for granted. That promise includes the support of family and friends, the sense of purpose and contribution to society through employment and meaningful activities, and the feeling of belonging and selfhood that comes from no longer defining oneself by an uncontrollable diagnosis, but by the proactive development and fulfillment of one's potential.

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Appendix A

Results of the 2004 Recovery Baseline Assessment

	% reflects recovery well	% reflects recovery less well
Intake/Assessment		
Evaluation of strengths	32	68
Type and frequency of age appropriate meaningful activities	34	66
Consumer's interests and choices related to care	30	70
Consumer's perspective on symptoms and impact on quality of life	42	58
Consumer's beliefs about recovery	11	89
Consumer's personal mechanisms for coping	12	88
Natural supports	46	55
Consumer's belief about recovery is supported by others	13	87
Treatment Plan		
Consumer's interests and choices for care are identified	42	52
Strategies to increase coping and regain independence are included	16	77
Plan supports consumer's participation in age appropriate, meaningful activities	40	60
Progress Notes		
Consumer involvement in age appropriate, meaningful activity documented	36	64

Appendix B

Client Outcomes

Number of clients who had the issue

	2000	2001	2002	2003	2004
Unemployed at start	13,464	7,866	8,308	8,713	9,789
Homeless at start	511	676	753	761	886
Incarcerated in the previous year	1,365	1,580	1,713	1,754	1,927
No age appropriate activity at start	4,482	5,842	5,812	4,768	5,372

Number of clients who achieved the outcome

	2000	2001	2002	2003	2004
Found employment	654	393	233	195	199
Found a home	197	236	231	206	245
Had fewer incarcerations	539	703	748	766	782
Developed age appropriate activity	1,218	1,157	1,641	696	588

Percent of clients who achieved the outcome

	2000	2001	2002	2003	2004
Found employment	4.9%	5.0%	2.8%	2.2%	2.0%
Found a home	38.6%	34.9%	30.7%	27.1%	27.7%
Had fewer incarcerations	39.5%	44.5%	43.7%	43.7%	40.6%
Developed age appropriate activity	27.2%	19.8%	28.2%	14.6%	10.9%

Total Clients Served in Outpatient Services, by Year

2000 23,551
2001 24,674
2002 23,269
2003 24,589
2004 26,144

Appendix C
Telesage Recovery Domains

	KCMHP Average	State Average
Adults		
(Scale is 1-5, higher is better)		
Have goals	4.0	4.1
Identify triggers	3.4	3.3
Deal with symptoms	3.5	3.3
Symptoms interfere less	2.6	2.4
Ask for help	3.3	3.2
Feel hopeful	3.4	3.3
Like self	3.3	3.2
Youth		
Hopefulness	16.5	15.9
Parent/Caregiver		
Hopefulness	16.9	15.7